HIV POLICY COLLABORATIVE

ISSUE PAPER: BEHAVIORS ENDANGERING PUBLIC HEALTH (BEPH)

1. PURPOSE

The purpose of this paper is to review case law, position papers and the various interpretations of BEPH in order to develop feasible policy options. This paper will present information about each policy option but will not recommend any particular option or combination of options, deferring this decision to the HIV Policy Collaborative.

2. BACKGROUND

The AIDS Omnibus legislation of 1988 included specific stipulations regarding the behaviors by someone with HIV intentionally exposing another and thereby putting the uninfected person at risk of acquiring HIV. Written as a deterrent to the willful spread of HIV this section authorized certain actions by the local health officer when such a case came to their attention. While "due process" steps were written into both the Revised Code of Washington (RCW) and Washington Administrative Code (WAC) describing those steps, a variety of interpretations and applications of those steps in individual cases have been attempted since then. The following paper outlines the specific sections of both the RCW and WAC, specific case law that have dealt with what has come to be known as Behaviors Presenting Imminent Danger (BPID) and Conduct (Behavior) Endangering Public Health (BEPH).

Definitions:

"Behaviors presenting imminent danger to public health" refers to an individual with a laboratory confirmed HIV infection engaging in specific activities (bulleted below) without informing their partner of their HIV status prior to engaging in the activity.

- Anal or vaginal intercourse without a latex condom;
- Shared use of blood-contaminated injection equipment;
- Donating or selling HIV-infected blood, blood products, or semen;

"Conduct endangering public health" refers to the same situation above and includes the following activities:

- Anal, oral, or vaginal intercourse for all sexually transmitted diseases.

For HIV and Hepatitis B:

- Anal, oral, or vaginal intercourse; and/or
- Sharing of injection equipment; and/or
- Donating or selling blood, blood products, body tissues, or semen; and
- Activities resulting in introduction of blood, semen, and/or vaginal fluids to:
    - Mucous membranes;
    - Eyes;
    - Open cuts, wounds, lesions; or
    - Interruption of epidermis.

A. Summary of Current Statutes

RCW 9A-36-011, (1) (b)
(1) A person is guilty of assault in the first degree if he or she, with intent to inflict great bodily harm:
(b) Administers, exposes, or transmits to or causes to be taken by another, poison, the human immunodeficiency virus as defined in chapter 70.24 RCW….

RCW 9A.36.021, (1) (e) – Used prior to RCW 9A-36-011, (1) (b)
(1) A person is guilty of assault in the second degree if he or she, under circumstances not amounting to assault in the first degree:
(e) With intent to commit a felony, assaults another; or…

RCW 70.24.024
A public health officer has the authority to issue increasingly restrictive measures if he or she has reasonable evidence that an HIV positive individual is engaging in behavior presenting imminent danger to the public's health. A public health officer can issue a cease and desist order to an HIV positive individual when there is evidence that they are engaging in specific activities that include and are not limited to unprotected sex or shared injection drug use. A public health officer can order a person to be detained for up to 90-days and require specific HIV prevention counseling if the individual continues high risk behavior after the order is issued and all other public health efforts have been exhausted.

NOTE: There is no evidence that detainment under these provisions by a public health officer has ever been used in Washington to date.

B. Public Health Practice and Interpretation of BEPH

The uses of the "Behaviors Endangering" components in law and regulation have been sporadic since instituted. While some local health officers have delivered a 'cease and desist' order, few jurisdictions pursued additional steps through local law enforcement. The following are notable public cases where law enforcement became involved in addressing intentional exposure by someone infected with HIV.

The HIV Criminal Law and Policy Project, with the Center for Law and the Public's Health, is funded by the Centers for Disease Control and Prevention to examine how laws influence sexual behavior among people with or at risk for HIV. This project identified 316 prosecutions nationally of persons for exposure or transmission of HIV between 1986 and 2001 and five of these prosecutions occurred in Washington State

The following case information is from a consolidated appeal made by Calvin Stark and documented through www.LegalWA.org.

State v. Calvin Edward Stark, 1990 Clallam County – Stark was charged with three counts of assault in the second degree under RCW 9A.36.021 (1)(e). During two separate trials Stark was found guilty of intentionally exposing his partners to HIV. On count one during the first (jury) trial Stark was issued a sentence exceeding the standard range for the crime based upon "future dangerousness." Stark later appealed and challenged the constitutionality of the second-degree assault statute for various reasons and that the exceptional sentence for count 1 was unjustified. The Court of Appeals affirmed all judgments with the exception of the sentence exceeding the standard range and remanded the case for resentencing.

Background

Stark tested positive for HIV on 3/25/88 and his status was confirmed by further testing on 6/25/88 and 6/30/88. Between 6/30 and 10/3 of the same year, Clallam County HD staff met with Stark five times to counsel him extensively about his HIV infection. The five sessions included information about safer sex practices, transmission of infection and the importance of notifying all sexual partners about HIV status prior to engaging in sexual activity with them.

On 10/3/88 the Clallam County Health Officer issued a cease and desist order after learning that Stark disregarded HD advice and engaged in unprotected sexual activity. Stark violated the cease and desist order and the Clallam County Health Officer approached the County Prosecutor (who also served as the County Attorney) to obtain judicial enforcement of the cease and desist order. The County Prosecutor used information provided by the Health Officer to complete a police report and contact the person who had reported the unprotected sexual activity. Based on the sexual contact's statements to police, the State then charged Stark with three counts of assault in the second degree. The Court of Appeals was asked to rule on the County Prosecutor's authority to use information provided for the purpose of a confidential judicial hearing to initiate a criminal prosecution. The Court ruled that this decision lay within the discretion of the prosecutor and was lawful.

The following case information is from an appeal made by Randall Louis Ferguson and documented through www.Findlaw.com.

State v. Randall Louis Ferguson, Superior Court, 1996 Clark County Washington - On September 26, 1996, a jury found Ferguson guilty on one charge of assault in the second degree under RCW 9A.36.021 (1)(e). Ferguson was given an exceptional sentence of 120 months on the basis of deliberate cruelty. Ferguson appealed the exceptional sentence and the Court of Appeals concluded that the record supported the trial court's finding of deliberate cruelty, which justified the sentence.

Background

On 1/26/88 Ferguson requested and received an HIV antibody test from Southwest Washington HD. Ferguson received his positive test result in person on 2/13/88 and was provided post-test counseling that included HIV transmission information and the importance of condom use to decrease transmission to others. On 7/24/91, Ferguson obtained additional counseling on HIV/AIDS from the SWWHD health officer.

In May 1994, Ferguson met a woman, told her he was HIV positive and engaged in sexual intercourse with her on three occasions. On the third occasion Ferguson removed the condom during intercourse (without partner consent), which was the event on which the conviction is based. On 6/28/95 the Clark County Prosecuting Attorney charged Ferguson with second-degree assault against the victim, "with intent to inflict bodily harm, did (intentionally) expose or transmit human immunodeficiency virus as defined in chapter 70.24 RCW, in violation of RCW 9A.36.021 (1)(e).

Information regarding the Anthony Whitfield is from On-line news reports (The Olympian and KIRO TV) and the "Behaviors Endangering Public Health" Power Point presentation to the AIDSNET by Dr. Diana Yu, Thurston County Health Officer.

On November 8, 2004, Anthony Whitfield was convicted in Thurston County of 17 counts of first-degree assault with sexual motivation, three counts of witness tampering and two counts of violating a court protection order.

Background

Whitfield was diagnosed with HIV in 1992 while incarcerated in Oklahoma. Thurston County Health District diagnosed three women with HIV between 5/02 and 12/03 all women identify Whitfield as a sex partner. Whitfield was issued a cease and desist on 3/11/04. Thurston County Health has contact with two female partners of Whitfield and learns that he had intercourse with both individuals (on 3/10/04 and 3/14/04 respectively) and both women were unaware of his status. The County Prosecutor takes over the case shortly after. Five of Whitfield's sexual contacts have tested HIV+.

Whitfield lied to sexual partners when asked directly about his HIV status. Two witnesses testified that Whitfield said that if he ever became infected with HIV, he would give it to as many people as he could.

Items noted as helpful in this case according to Thurston County Public Health Official, Dr. Diana Yu.

- An HIV counseling and testing policy;
- Having clients sign a post-test counseling for acknowledging that they have received counseling;
- A standardized Health Officer Order that spells out what you want the person to do;
- Adding the charge of sexual motivation – Whitfield is now classified as a sex offender and subject to notification if he ever gets out.

C. Positions on Behaviors Endangering taken by Providers and Constituents

Policy positions on "Behaviors Endangering" have been forwarded by several organizations in Washington State including the AIDSNET Council and the Lifelong AIDS Alliance. These positions are summarized below. The positions have been considered in attempts to address the lack of consistency of interpretation and application of the current law.

AIDSNET (*AIDNET Council Issue Paper 6, March, 2003*)

The AIDSNET Council outlines current procedure in WAC 246 -100-206 as a barrier to protecting the public's health in cases where an individual is known to be HIV+ (evidence of infection) and engaging in behavior endangering public health.

Barriers to Current BEPH Measures

- HIV is a life-long infection and a cease and desist order extends only 90 days. Individual may perceive that preventive actions are no longer necessary after the three-month period.
- The health officer is unable to take additional measures unless the infected person resides in the area where the health officer has jurisdiction and endangers public health during the 90-day cease and desist order is in effect.
- The additional report of endangering public health must be made to a health officer during the cease and desist order for the health officer to pursue the detention of an infected individual. Most BEPH reports are received passively and the health officer is unlikely to pursue detention for this reason. Current evidence does not show that detention of HIV+ persons is a useful measure.

Lifelong AIDS Alliance (*Lifelong AIDS Alliance Behaviors Endangering Issue Paper, November, 2004*)

Lifelong AIDS Alliance (LLAA) believes too much effort is spent finding ways to criminalize HIV with no demonstrable result. Lifelong states that most HIV+ individuals take appropriate action to

prevent the transmission of HIV and feel a sense of responsibility to protect their sex partners. The criminalization of HIV exposure or transmission is used by numerous states including Washington to address individuals who intentionally or negligently transmit HIV infection. LLAA has not found evidence that show criminal law leads to a reduction in HIV infections. Effective prevention and counseling programs are needed to reduce HIV risk behaviors during incarceration and after the completion of a criminal sentence.

Additional concerns

- Many criminal statutes are vague and allow for arbitrary or prejudicial enforcement of the law. Even in states where the statute requires intent to transmit the virus, this intent is difficult to define and establish.
- HIV is rarely prosecuted as a distinct crime. More than 70% of individuals charged with an HIV-related crime were already being prosecuted for another offense. Existing racial disparities in the criminal justice system combined with disproportionate rates of HIV among people of color opens the door to racially biased enforcement of HIV exposure/transmission laws.
- There is no evidence to prove that HIV criminalization laws 1) effect behavior change, 2) result in a reduced number of HIV infections or 3) address the complex social issues and psychological barriers to informing sexual and needle-sharing partners of HIV status.
- The stigma associated with HIV makes it difficult for an individual to disclose their HIV+ status. An increase in HIV-specific criminal statutes could lead to increased stigmatization of HIV+ individuals and discourage disclosure.

Lifelong supports the continued search for effective behavior modification programs.

The HIV Policy Collaborative

The HIV Policy Collaborative has discussed at length 'Behaviors Endangering' during the June 30, 2004 and September 24, 2004 meetings. The Collaborative has not formalized an opinion or position regarding BEPH to date. (Members of the Collaborative include Lifelong AIDS Alliance and the AIDSNET and their positions are reflected above.) The September meeting included the expertise of University of Washington Law Professor, Dr. Patricia Kuszler and Thurston County Deputy Prosecutor, Jon Tunheim.

During these meetings, the Collaborative brainstormed some guiding principles to consider in any development of BEPH policy options. Those principles include:

- Need agreement on a clear definition of 'behavior endangering"
- Inability to identify a bona fide legal deterrent
- Continue to persuade individuals to seek public health services while still protecting confidentiality
- Assure collaboration and avoid pitfalls between willing partners: providers; attorneys; public health and law enforcement
- Need for evidence-based behavior modification interventions
- Need for available and accessible local programs/ resources
- Clarification of the role of public health versus the criminal and civil system

In addition there were both issues and barriers discussed regarding current statute.

- A representative of local health officers stated that many officers do not find the current statute useful and feel the rule should be updated or modified.
- A representative from the medical community indicated that many clinicians do not notify public health in BEPH situations because:
    - Response from public health is not an improvement over what clinician can provide themselves

- There are not enough resources
- Clinicians need to be assured that notifying public health does not increase liability risk with regard to patient confidentiality

D. <u>Challenges of Invoking BEPH</u>

RESEARCH
There is little research illustrating the impact of the criminalization of HIV exposure and transmission on decreasing individual risk behavior or as a deterrent to certain sexual/ drug use behavior within society. Two main sources of information, data and opinion on BEPH issues for this section include:

1. The HIV Criminal Law and Policy Project, Principal Investigator and co-investigator for this project are Zita Lazzarini, J.D., MPH and Scott Burris, J.D. respectively through the Center for Law and the Public's Health at Johns Hopkins and Georgetown Universities. Information and data is summarized from their 2002 paper, *Evaluating the Impact of Criminal Laws on HIV Risk Behavior.* The Project's ongoing activities can be viewed through www.hivcriminallaw.org; and

2. Lawrence O. Gostin, the director of the Center for Law and the Public's Health at Georgetown and John's Hopkins Universities is a leading authority on AIDS policy. Information from Gostin's book, *The AIDS Pandemic: Complacency, Injustice and Unfulfilled Expectations, is included in this section.*

INTENT OF HIV-SPECIFIC STATUTES
A clear view of the intent of the law is necessary to determine the effectiveness of an HIV exposure/transmission statute to decrease HIV infection. For example; is the statute designed to protect the public's health by removing the offender or deter the rest of society from engaging in a particular behavior(s)? One challenge is that there is no commonly applied model of research to determine the effectiveness of a criminal method (deterrence, incapacitation etc.) upon HIV transmission.

The Paradox:

The behavior most widely accepted as wrong – deliberately using HIV as a tool to harm or terrorize another – is too rare to influence the epidemic, whereas the behavior most responsible for spreading the virus – voluntary sex and needle sharing – is difficult and controversial to prohibit (Lazzarini 2002).

ENFORCEMENT AND PROSECUTIONS
Washington State is one of 25 states with an HIV specific statute with five prosecutions between 1996 and 2001. The Anthony Whitfield conviction is not yet a part of the HIV CLAPP research and brings the state total to 6.

Research does not support a systematic enforcement of HIV exposure laws across the United States. The HIV CLAPP research shows that the main factor in determining who gets prosecuted is "the accident of being caught and brought to the attention of a willing prosecutor". The one characteristic that is shared by many charged with an HIV-related crime is that the alleged behavior was criminal regardless of HIV. More than seventy percent committed their HIV-related illegal act in the course of a sex crime, an assault or act of prostitution (Lazzarini 2002). Specific information about the individuals charged was not available to better understand why these particular people were targeted. Research does show that the individuals charged were convicted in most cases and often received felony sentences when convicted of violating an HIV specific statute.

CHALLENGES OF HIV-SPECIFIC STATUTES

The HIV CLAPP did not find that HIV specific statutes outline the clearest rules to criminally impact dangerous behavior. The clearest statutes target behavior that is clearly illegal such as intentionally infecting another person. However, statutes written for voluntary sex are often so broad that they criminalize behavior on the basis of the sex act occurring without prior verbal disclosure of status by the infected partner. These statutes do not account for preventive actions such as condom use, engaging in less risky sexual behavior or the non-verbal determination of partner status that occurs. Gostin discusses the benefit of criminal prosecution in severe cases where an individual makes a calculated decision to infect other (s) in achieving "deterrence of high-risk behavior, punishment of morally blameworthy individuals and incapacitation and rehabilitation of dangerous persons". "The criminal system is less likely to achieve its goals when the risk is negligible and the individual in question is a minimally dangerous person". Individuals may be less likely to access HIV testing and counseling and partner notification if the information they provide puts them at risk of prosecution. It may also place further mistrust by this population on other public health programs and services.

DETERMINING TREATMENT OPTIONS: BEHAVIOR MODIFICATION

The target population for BEPH cases are individuals that live with HIV and may have other issues that contribute toward risk behavior such as drug and alcohol addiction, sexual addiction, sexual abuse and undiagnosed or untreated mental health disorders. There is research to support the behavior modification of very high-risk persons through a variety of non-criminal sources in the HIV prevention, chemical dependency treatment, sex addiction treatment and sex offender treatment arenas.

The feasibility of options should be considered to reflect available services in both the rural and metropolitan areas of the state. It is necessary for the rehabilitation/ treatment option(s) to be offered to all individuals that are either in the criminal justice system or public health system due to BPID and BEPH. The options should also include access to appropriate HIV services such as case management and physicians with experience in treating HIV.

Highly active antiretroviral therapy (HAART) should be provided in any rehabilitation efforts for individuals who are voluntarily willing and able to follow the treatment regimen. HAART often allows the immune system to fight infections and prolong life, while likely decreasing the ability to infect others by decreasing (often to undetectable levels) the viral load in blood and other body fluids that transmit the virus during sex and drug use behavior.

The University of California at San Francisco analyzed data collected through the Young Men's Health Study in San Francisco between 1994 and 1999 and concluded that anti-retroviral therapy (available since 1996) reduced HIV transmission by 60% (Porco T, Martin J et al, AIDS, 18 (1): 81-88, January 2, 2004, *Decline in HIV infectivity following the introduction of highly active antiretroviral therapy*). Researchers considered several factors such as sexual practice and condom use in estimating an HIV negative gay man becoming infected, per sexual partner. There was a 60% decrease in probability from data that was pre HAART availability to HAART availability.

Further research indicates an increase in unprotected sexual behavior among this population that may be a result of HAART. The undetectable viral lodes that can occur with HAART may contribute to a false sense of security among HIV positive individuals around the need for protective behavior like condom use. This information should be considered when including this treatment regimen for individuals participating in rehabilitation programs for BPID/ BPEH.

3. POLICY OPTIONS

Given this background there seems to be several options for the Collaborative to consider in further discussion of Behaviors Endangering. They fall into essentially four categories:

- no change to the current law;

- totally remove the current law (leaving issue solely to criminal justice system);
- consider rehabilitation when cases come to the attention of a local health officer; and
- refer to law enforcement any case that meets the criteria of 'behaviors endangering'.

The pros and cons of each are considered below.

POLICY OPTIONS	PRO	CON
CURRENT STATUTE	**-** Not perfect, provides a guide.	- Little faith in current approach by PH and medical professionals. - Cease and desist only 90-days. - Detainment measure has never been used.
REMOVE CURRENT STATUTE	**-** Opportunity to consider new approach to meet overall goal.	- Nothing in place while other options are considered. - Cumbersome/ time consuming process to enact new statute (and any subsequent rulemaking.
REHABILITATION (COMMUNITY BASED) Prevention Case Management, Sex Offender Tx Model, Chemical Dependency Tx Model	- Opportunity to consider new approach to meet overall goal of behavior change and protecting PH.	**-** Costly - Time consuming - Research not clear for BEPH arena
CRIMINAL ENFORCEMENT	- Clarifies lack of any public health role - Incapacitates high-risk persons. - Protects community public health.	- No research to support behavior change or effect on HIV epidemic. - May re-direct infection to jail or prison. - Possible civil rights issues. - PH seen as breaking confidentiality and incapable of dealing with high-risk persons.